Pursuing Perfection (P2) in CHRONIC AND COMPLEX CONDITIONS

Learnings from
Pursuing Perfection, (Whatcom County, 5yrs)
COHE (16 WA counties, 4 yrs), and
CareOregon (Portland, OR, 4 yrs+)

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www.sharedcareplan.org
www.wwpp.org

Who is “We”?

Where is “Home”?

Care is Broken
Between our Organizations
Where the Patient Lives

Systems and their Subsystems
Systems have Purpose

VISION: Washington State to Lead the Nation

- Cross-organizational, cross-agency, cross-community Cooperation and Coordination
- State-wide Health Information Integration
  - Patients at the very center
  - Every person with their own health tools
- The Sate Leads
  - As employer
  - As payer
  - As convener and sense maker

WA HEALTH INTERSECTIONS & OPPORTUNITIES

- Government interested and becoming focused
- Cooperative disposition
- Chronic and complex care & costs
- Health information technology (HIAAB+)
- COHE/P2 for Chronic & Complex Conditions
- Personal Health Record Industry for WA
- Life Sciences Fund—research and learning about the above intersections

Three Simple Ideas

- Co-design with patients
- Fund this special care manager role
- Provide a special kind of personal health record and shared care plan

One Bold Idea

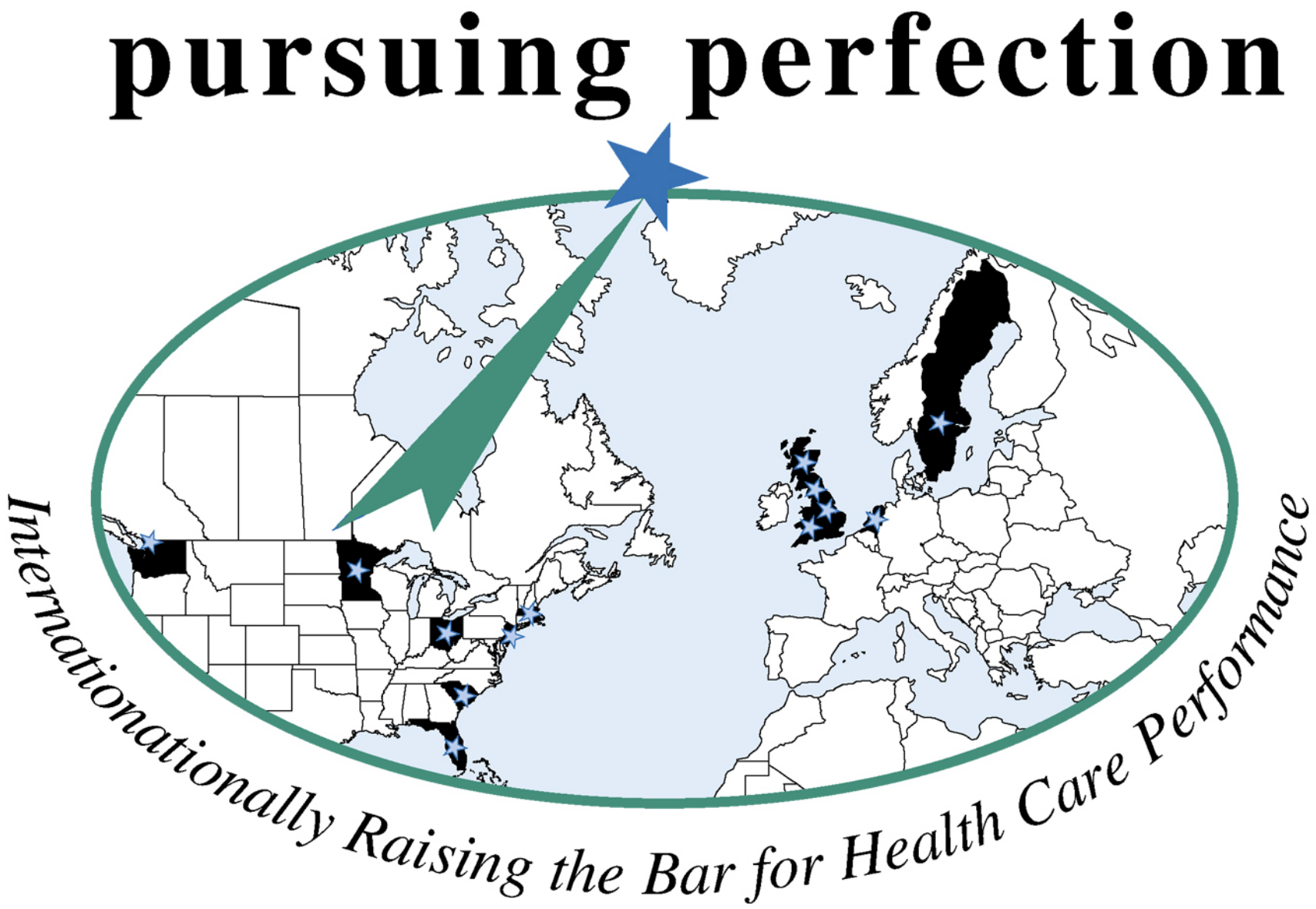
- Communities and organizations can work together on essential infrastructure
  - Care Managers
  - PHRs (patient health records)-
    - The patient home is a clinical microsystem and the patient and family are ‘primary” care givers.
    - Firemen and EMTs (EMS) and others can help
- Community-based “utilities” make sense

Acute Care
vs.
Chronic Conditions, Prevention, and Lifestyle

Overlapping but
FUNDAMENTALLY DIFFERENT

Non-acute care requires community assets.

CONTEXT


pursuing perfection
Internationally Raising the Bar for Health Care Performance

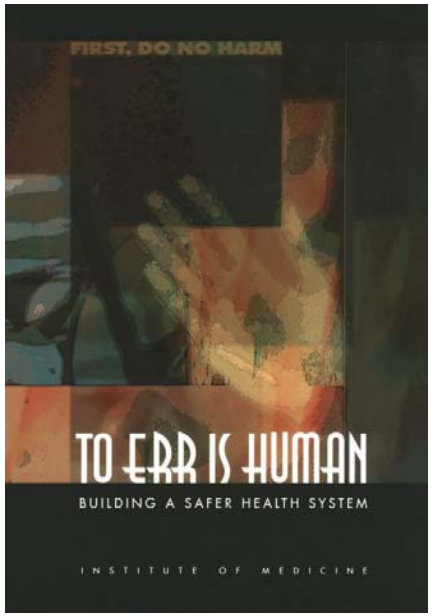
PURSUING PERFECTION

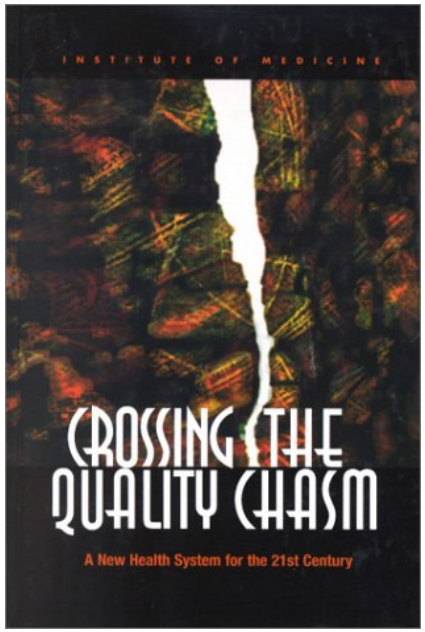
Institute of Medicine

Robert Wood Johnson Foundation

Institute for Healthcare Improvement

Four countries, 13 participants, at least Six Communities





IOM

- "Not an indictment of physicians, nurses, or, indeed any of the people who give or lead care."
- "…futile to seek the improvement by further burdening an overstressed health care workforce or by exhorting committed professionals to try harder."
- "A redesigned health care system can offer the health care workforce what it wants—a better opportunity to provide high-quality care."

CHASM

- Your ideas?
- What would you do if **YOU** had to take it seriously?
- Any serious ideas that match the size of the problem
  - Scale well
  - In time for the demographic budge
- RWJF took a $30M bet on Pursuing Perfection.
  - How do the innovations move to scale?
- How much of the solution is Heath Information Technology?
  - How far will it get us as now conceived?
  - Will the **relationships** change enough to take advantage of the technology?
  - What evidence?
- To Err Is Human, Chasm Report, IOM on “Nursing Safety”
- What do you make of McGlynn’s papers
  - Worrisome or liberating?
  - A call for a parallel approach?

Robert Wood Johnson Foundation:

“Transform American Health Care”

Give me a break!

or

Take it seriously?

FOUR CONCLUSIONS

1. Patients are competent in their world and we are not the center of their worlds and never will be nor should be.
2. We need patients as partners if we are going to take responsibility for the quality chasm
   - Symmetric relationships are more fun and human for everyone
3. "Care Management" & Personal HIT must work for the patient across organizations, including providers and payers.
   - It must also add value to providers (workflow) and payers.
4. Health information, technology and interactions can and will move to their world. We should all help.
   - Especially for chronic conditions, prevention, and lifestyle.

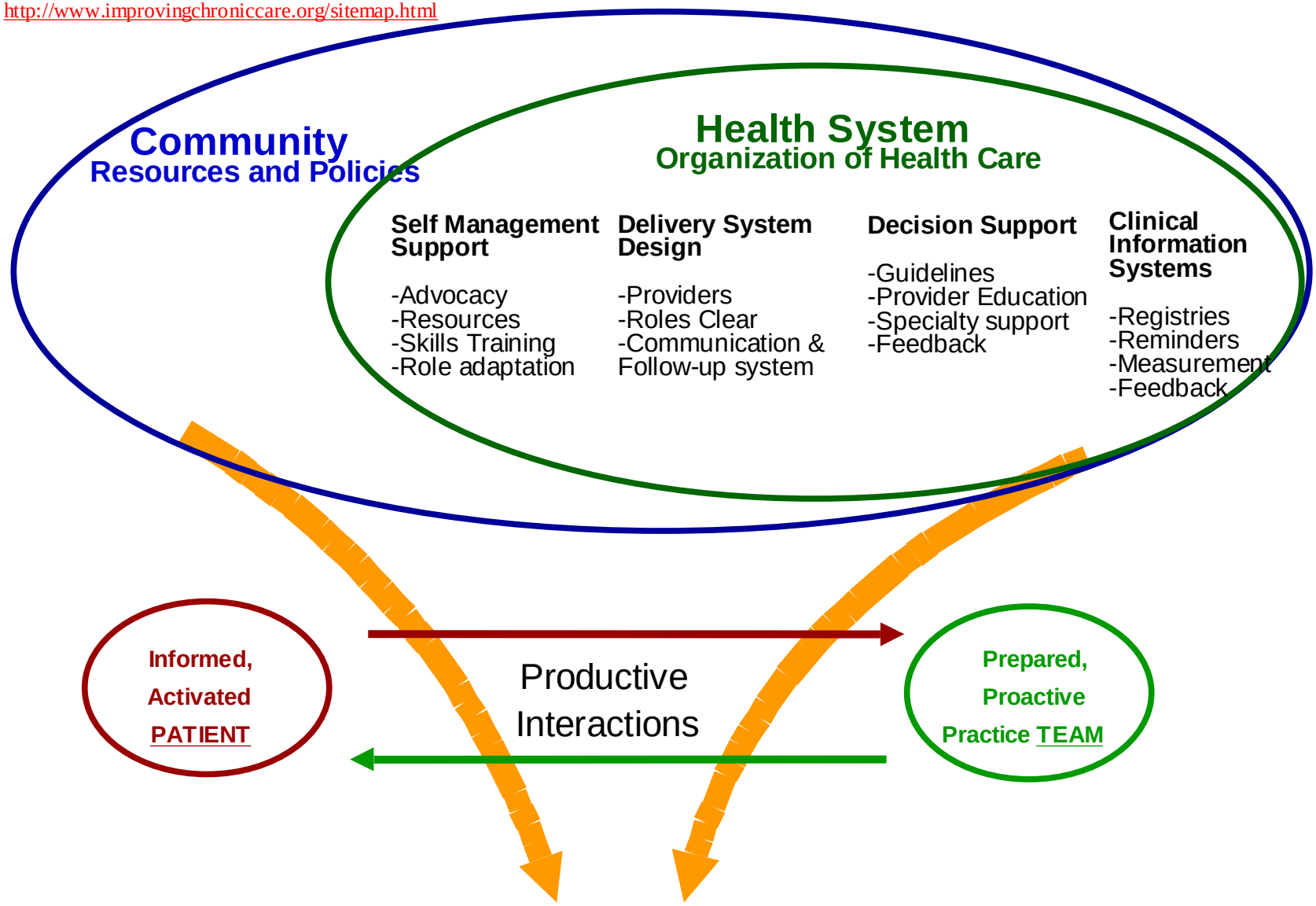
In Whatcom County, WA we invited patents to redesign the system to support those with chronic conditions.

- They created:
  - A new Role-The Clinical Care Specialist, and
  - The Shared Care Plan, a personal health communication tool.

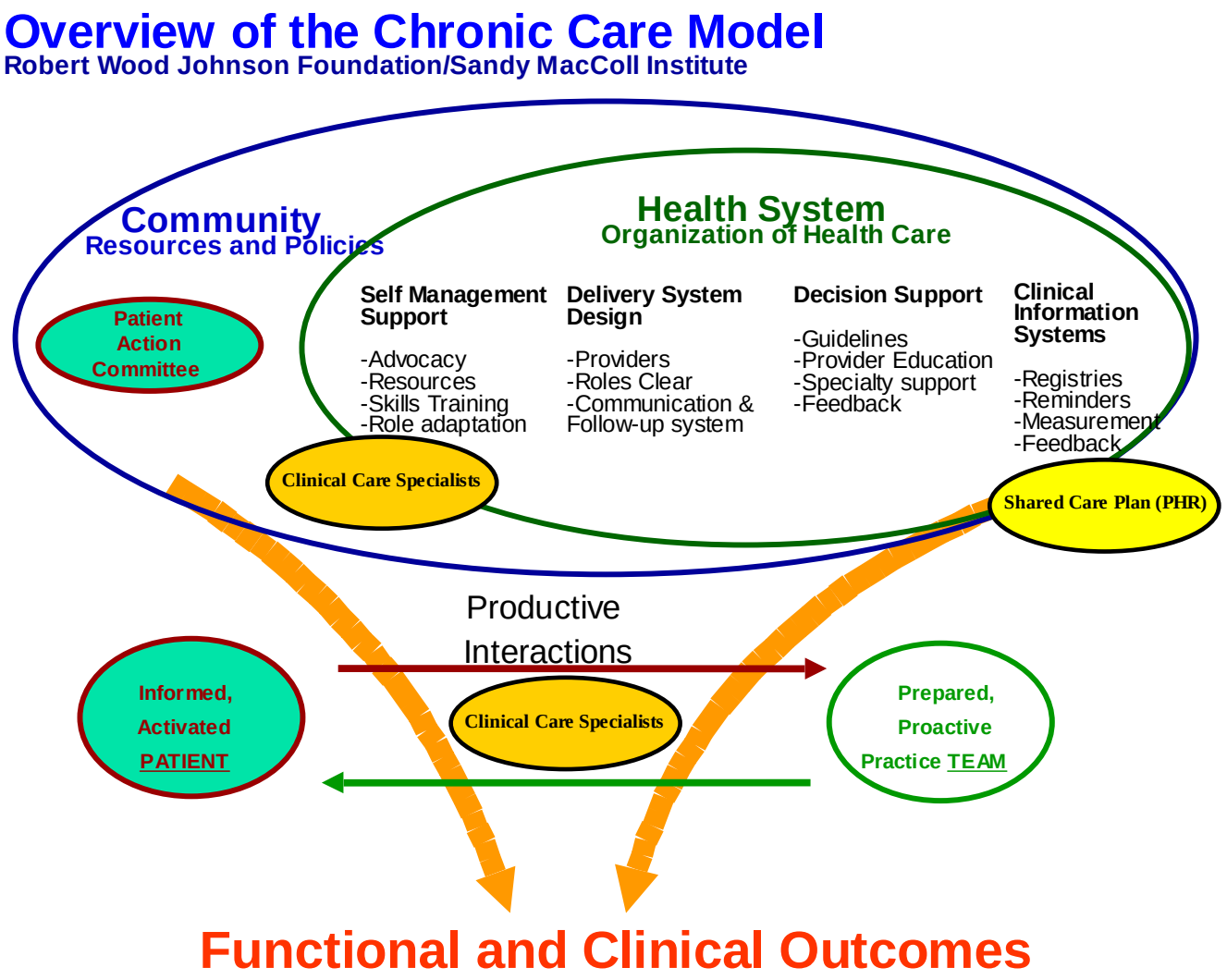
Overview of the Chronic Care Model

Robert Wood Johnson Foundation/Sandy MacColl Institute

http://www.improvingchroniccare.org/sitemap.html



Chronic Care Model—
A Useful Affordable Approximation



“Project Goals”

- Goal—discover how to deliver near perfect care for all chronic conditions
- Emergence vs. Planning in Complex Adaptive Systems
  - Listening directly to patients. A whole new view emerges--theirs
- Effects of program:
  - Patient satisfaction and activation
  - Saves lives
    - Rescues--Medication errors, earlier interventions,
    - Upstream--patient activation, less depression
  - Saves money
    - $3,033/pt/year in decreased ED and Hosp costs
    - (CareOregon saves $6,000/pt/year)

Critical Elements

- Community cooperation
- PATIENTS
  - Patients as co-designers
  - Patients as providers
  - Home as clinical microsystem
- “Clinical Care Specialists”
- Shared Care Plan, as special Personal Health Record
- BIGGEST PROBLEM—savings don’t fund operations. Medicare and/or Medicaid can easily change this single flaw.
  - Money goes to pharmaceuticals and payers and not to support the missing elements—CCS, SCP

Only Possible Next Step?

- Payers with interest in whole communities must carry the baton
  - Medicaid
  - Medicare
  - Community Health Clinics
- They must engage or create organizations that can integrate and coordinate care from the home into the whole commnity
  - Area Agencies for Aging

“Outreach”

- “Train wrecks” (chronic and complex patients) from participating organizations.
- Any payer (no payer) since grant and community funded for 5 years

P2 Participating Orgs

- Family Care Network
- Sea Mar Community Health Clinics
- North Cascade Cardiology
- St. Joseph Center for Senior Health
- St. Joseph Hospital
- Group Health Cooperative
- Community Health Plan of Washington
- **AND LOTS OF PATIENTS**

Key Results

- Best diabetes outcomes in the county
- Saves money
- Patients, families, physicians value it highly
  - http://www.wwpp.org/media/fla/whatcomProf/whatcomProf.html
- Patient activation increases measurably

Comprehensive & Multidimensional Care

- The whole point is to understand & improve the patients medical outcomes in the context of their lives and living situations.
- This is not simply a “professional” model.
  - The professional model in isolation is bankrupting us and is not able to deliver the care with our help. The only question is:

    What should that help be?

Comprehensive & Multidimensional Care

- What should that help be?
  - **"Clinical Care Specialists"**
    - "Navigate" the system with them
      - Medical, Financial, Social, Support
    - "Coach"
      - Support the patient and family in self management
    - "Translate"
      - Help patients and providers understand one another
    - "Life guard"
      - Orchestrate interventions before ED or hospitalization
  - **Shared Care Plan**

Continuity

- The relationship between CCS and patient is meant to be continuous
- The CCS role has been at the community level with access to all physician practices
- CCS is very available to patient any time

Self-Management

- “Coach” role has been at the center from the start
- On going teaching and learning from CCS, other patients (group visits), CDEs, and Dieticians, etc.
- Group education events re diabetes

Social and Family Context

- CCS visit in homes
- Understands that the home is really the clinical microsystem for chronic conditions
- Shared Care Plan
  - Tool for social support for medical conditions
  - “Virtual Care Team”

Support for Lifestyle Changes

- Choric care is all about behavior change
- Behavior only changes based upon meaningful conversations and commitments between people
- Shared Care Plan and Clinical Care Specialists engage patients and families and providers in conversations.
  - See patient and family story @ http://www.wwpp.org/media/fla/BonnieWWPP2/TestVid.html
- Patient Activation Measure (PAM) is a developmental measurement tool for patient empowerment

You Have to Know What Is Most Important

- *It's about BEHAVIOR CHANGE*
- *It's about missing conversations that result in behavior change*
- *It's about Patient Activation*
  - *Which results in better health outcome and lower costs*

Missing Conversations

- The focus shifts
  - from EMR
    - (organization specific business medical records)
  - to include PHR (patient health record) that patients share as they like

Let’s Give Them a Chance

- With the devastating knowledge from the McGlynn reports.
- Let’s empower patients and their social networks in order to get this nation above 55% reliability in health care
- Let’s let them help us make it safer
- Let’s let them help us with the very difficult job of delivering health care
- Let’s invite them in as full partners
- Let’s get them the navigator, coach, translator, lifeguard they need and we need

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

N ENGL J MED 348;26 www.NEJM.ORG JUNE 26, 2003

…systematic information about the extent to which standard processes involved in health care — a key element of quality — are delivered in the United States.

conclusions

The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.

?

Only Half Right !

Table 3. Adherence to Quality Indicators, Overall and According to Type of Care and Function.

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				
Preventive	38	6711	55,268	54.9 (54.2–55.6)
Acute	153	2318	19,815	53.5 (52.0–55.0)
Chronic	248	3387	23,566	56.1 (55.0–57.3)
Function				
Screening	41	6711	39,486	52.2 (51.3–53.2)
Diagnosis	178	6217	29,679	55.7 (54.5–56.8)
Treatment	173	6707	23,019	57.5 (56.5–58.4)
Follow-up	47	2413	6,465	58.5 (56.6–60.4)

We leave the patient out !

Table 4. Adherence to Quality Indicators, According to Mode.

Mode	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Encounter or other intervention	30	2843	4,329	73.4 (71.5–75.3)
Medication	95	2964	8,389	68.6 (67.0–70.3)
Immunization	8	6700	9,748	65.7 (64.3–67.0)
Physical examination	67	6217	19,428	62.9 (61.8–64.0)
Laboratory testing or radiography	131	5352	18,605	61.7 (60.4–63.0)
Surgery	21	244	312	56.9 (51.3–62.5)
History	64	6711	36,032	43.4 (42.4–44.3)
Counseling or education	23	2838	3,806	18.3 (16.7–20.0)

Horrible

Nothing > 4/5

> 60%

Table 5. Adherence to Quality Indicators, According to Condition.*

Condition	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)
Senile cataract	10	159	602	78.7 (73.3–84.2)
Breast cancer	9	192	202	75.7 (69.9–81.4)
Prenatal care	39	134	2920	73.0 (69.5–76.6)
Low back pain	6	489	3391	68.5 (66.4–70.5)
Coronary artery disease	37	410	2083	68.0 (64.2–71.8)
Hypertension	27	1973	6643	64.7 (62.6–66.7)
Congestive heart failure	36	104	1438	63.9 (55.4–72.4)
Cerebrovascular disease	10	101	210	59.1 (49.7–68.4)
Chronic obstructive pulmonary disease	20	169	1340	58.0 (51.7–64.4)
Depression	14	770	3011	57.7 (55.2–60.2)
Orthopedic conditions	10	302	590	57.2 (50.8–63.7)
Osteoarthritis	3	598	648	57.3 (53.9–60.7)
Colorectal cancer	12	231	329	53.9 (47.5–60.4)
Asthma	25	260	2332	53.5 (50.0–57.0)
Benign prostatic hyperplasia	5	138	147	53.0 (43.6–62.5)

Hyperlipidemia	7	519	643	48.6 (44.1–53.2)
Diabetes mellitus	13	488	2952	45.4 (42.7–48.3)
Headache	21	712	8125	45.2 (43.1–47.2)
Urinary tract infection	13	459	1216	40.7 (37.3–44.1)
Community-acquired pneumonia	5	144	291	39.0 (32.1–45.8)
Sexually transmitted diseases or vaginitis	26	410	2146	36.7 (33.8–39.6)
Dyspepsia and peptic ulcer disease	8	278	287	32.7 (26.4–39.1)
Atrial fibrillation	10	100	407	24.7 (18.4–30.9)
Hip fracture	9	110	167	22.8 (6.2–39.5)
Alcohol dependence	5	280	1036	10.5 (6.8–14.6)

Who Is at Greatest Risk for Receiving Poor-Quality Health Care?

Steven M. Asch, M.D., M.P.H., Eve A. Kerr, M.D., M.P.H., Joan Keesey, B.A., John L. Adams, Ph.D., Claude M. Setodji, Ph.D., Shaista Malik, M.D., M.P.H., and Elizabeth A. McGlynn, Ph.D.

N ENGL J MED 354;11 www.NEJM.ORG MARCH 16, 2006

In this study, we have now shown that individual characteristics that often have a protective effect do not shield most people from deficits in the quality of care. As the Institute of Medicine has concluded, problems with the quality of care are indeed widespread and systemic and require a system-wide approach.

What system could work?

Table 2. Adjusted Percentage of Recommended Care Received by Participants, According to Characteristic.*

Characteristic	Adjusted Percentage (95% CI)	P Value†
Sex		
Female‡	56.6 (55.8–57.3)	
Male	52.3 (51.2–53.3)	<0.001
Age		
18–30 yr‡	57.5 (56.1–59.0)	
31–64 yr	54.8 (54.1–55.6)	0.001
≥65 yr	52.1 (50.2–53.9)	<0.001
Race or ethnic group		
White‡	54.1 (53.4–54.8)	
Black	57.6 (55.5–59.7)	<0.001
Hispanic	57.5 (55.3–59.6)	<0.001
Other	55.4 (52.4–58.4)	0.40
Education		
Did not complete high school‡	54.6 (52.7–56.4)	
High school	54.1 (53.1–55.1)	0.66
College or graduate school	55.7 (54.8–56.5)	0.29
Annual household income		
<$15,000‡	53.1 (51.7–54.5)	
$15,000–$50,000	54.7 (53.8–55.7)	0.07
>$50,000	56.6 (55.5–57.7)	<0.001
Health insurance		
None‡	53.7 (51.3–56.1)	
Medicaid	54.9 (52.4–57.5)	0.50
Medicare	56.9 (55.4–58.5)	0.03
Managed care	55.2 (54.1–56.2)	0.27
Private nonmanaged care	53.6 (52.5–54.8)	0.94

WHAT DO YOU MAKE OF THAT?

IMPLICATONS FOR IMPROVEMENT STRATEGIES?

PATIENTS AS DESIGNERS

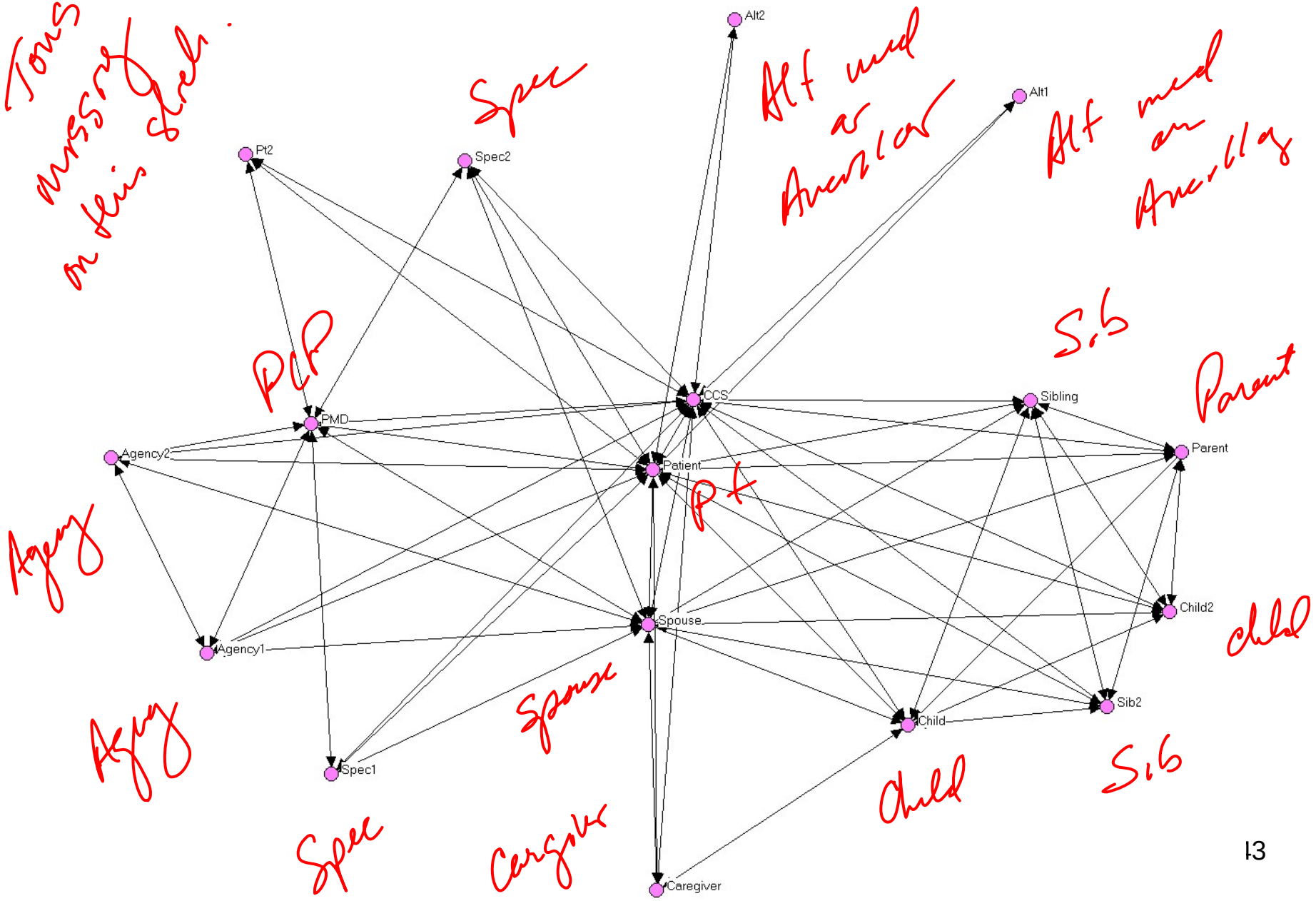
- Great experience
  - Don’t confuse advocates with patients
- Great ideas
  - Simpler
  - Cheaper
  - More effective
- Engages the heart of providers
- Engages elected officials at all levels
- 100+ patients on teams this year

Involving Patients in the Process

PATIENTS' EXPERIENCE

http://www.wwpp.org/media/fla/whatcomProf/whatcomProf.html

One Persons Health Network



A Patient Health Record, of a particular kind

- "Shared Care Plan" (http://www.sharedcareplan.org)
  - Supported by RWJF, Whatcom County patients and providers, including PeaceHealth. Software available for other communities for "free"
- Patient designed for self management and communication
- Invite providers, family, friends
- Includes
  - Patient preferences, goals, plans, actions
  - Medications (linking to EMRs supported by AHRQ)
  - Diagnoses
  - Linked to Healthwise
  - Medical history (in Oct., '04)
  - Advanced directives
  - Future--Test results & images
- We are committed to standards for interoperability
  - Continuity of Care Record as future standard?
- 800+ users in Whatcom

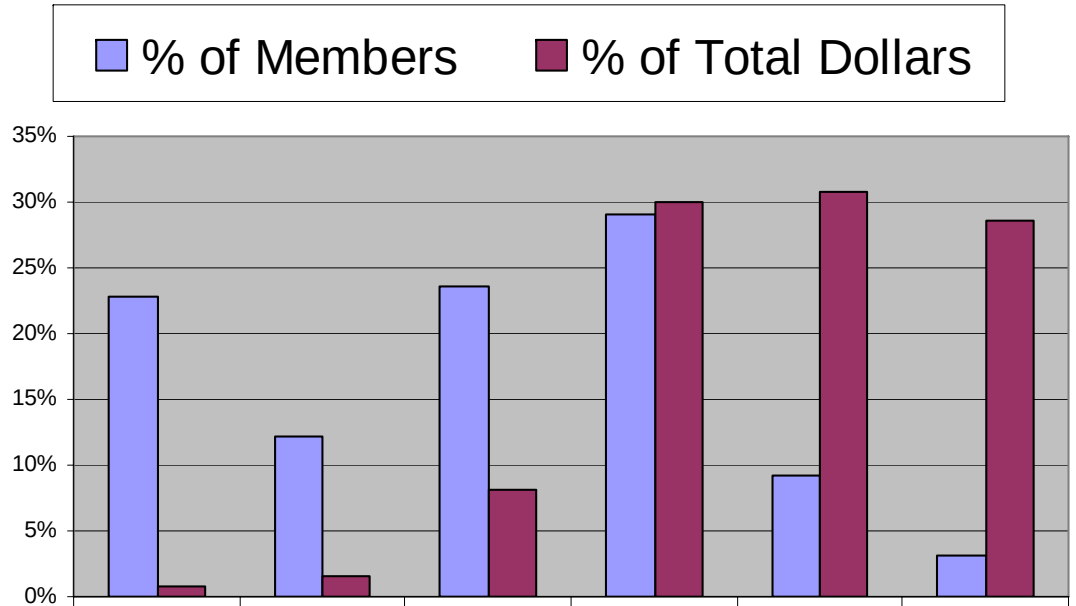
CareOregon

- Two years experience
- Saving $5-6K PMPM for most complex cases
  - (3% of patients—30% of total csots)
- Saving significant $ on less complex cases.
  - (9% of patients—30% of total costs)

“Typical” Utilization Pattern

CareOregon

April 1, 2002 - March 31, 2003
Includes Members with >4 months Enrollment Only



	Non Users	Healthy Users	Low	Mod	High	Very High
% of Members	23%	12%	24%	29%	9%	3%
% of Total Dollars	1%	2%	8%	30%	31%	29%

Program Dollar Savings

CM	Paid 2003	Paid 2004	Paid Change
Brief CM (n=1661)	$13,094,069.59 (pmpm $709)	$11,777,395.49 (pmpm $651)	-$1,316,674.10
No CM (n=59399)	$73,751,101.62 (pmpm $127)	$77,671,595.11 (pmpm $127)	$3,920,493.49
CM (n=326)	$5,272,876.82 (pmpm $1525	$3,765,855.28 (pmpm $1037)	-$1,507,021.54

~$5,000 Unadjusted Savings /case

But: Are the Savings from Case Management?

Did the sick members just get better?

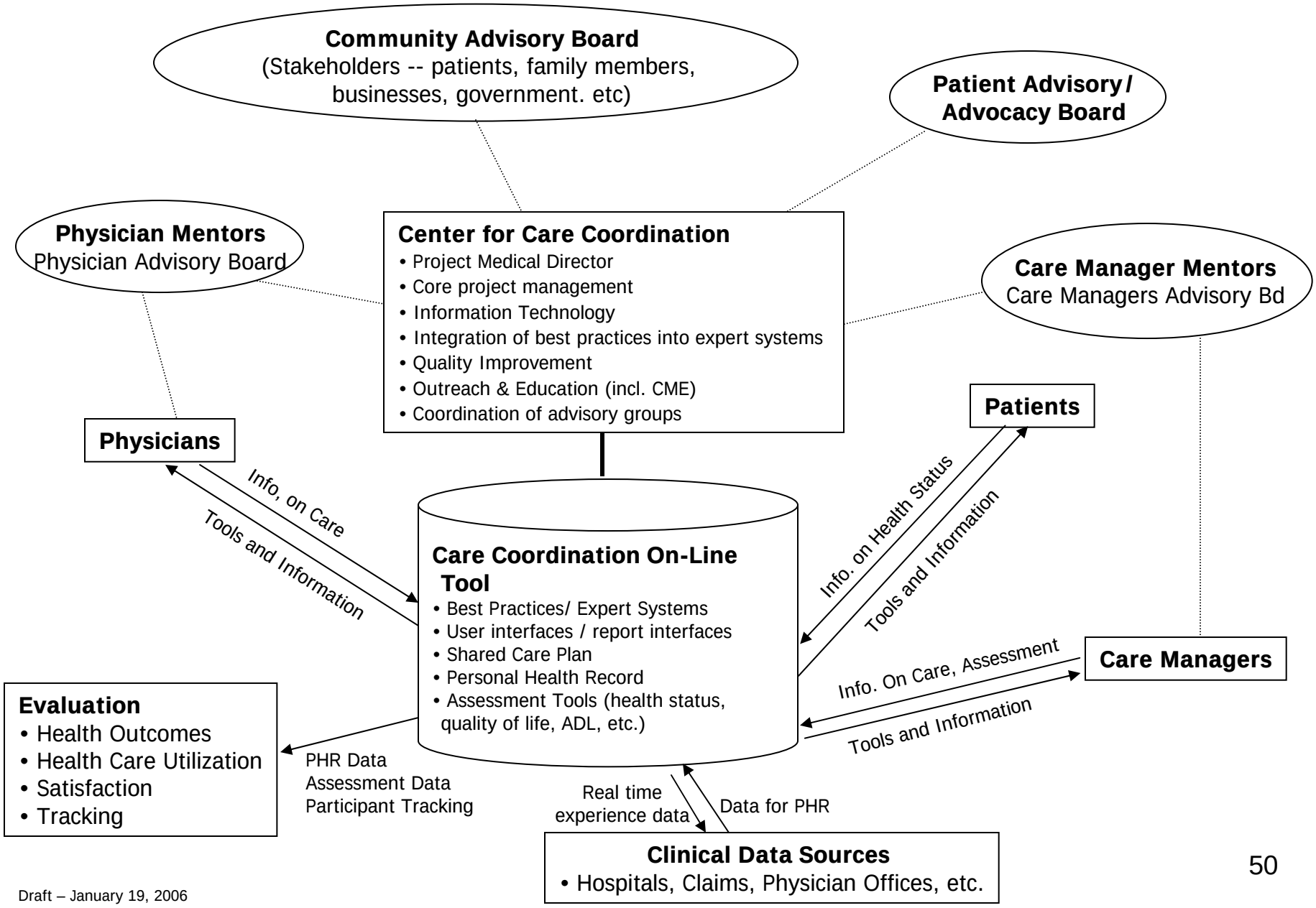
A POSSIBLE STATE-WIDE INTEGRATING INFRASTRUCTURE

1. COHE & Pursing Perfection
2. Area Agencies on Aging
3. Payers contract for services across all Washington Communities
    1. Medicare Advantage Plans
    2. Medicaid
    3. Self insured
    4. Commercial Payers

Area Agencies on Aging

- Local
- Situated
  - aware of context of patients, families, community resources, and providers' world
- Holistic
- Trusted
- Willing and able to work with physicians and hospitals
- Threatened by less holistic, less situated approaches
- Need to, and willing to step up to the challenge

Care Coordination Demonstration Project
Built on CHOE and Purusing Perfection



THANK YOU

Boundary of a System

The boundary of the system to be described may be drawn around a single company, or around an industry, or as in Japan in 1950, the whole country. The bigger be the coverage, the bigger be the possible benefits, but the more difficult to manage.

– Deming, The New Economics, p. 55

Some things can be easily managed at a large scale while others cannot. Look for those that can and “should” scale to the “community” level.

– Me

Debilitating Assumptions

1. Chronic care is like acute care
2. Old people are incompetent
3. Doctors and hospitals are the center of health caring
4. It's OK for every payer to provide different and remote "care management"
5. It's OK for every business to "provide" a different PHR (or even worse only and EMR)
6. People cannot get access to the web
7. Everyone needs to work on line and work from a computer
8. Everyone must adopt PHRs before they are useful
9. Business medical records must be adopted before personal health records/support systems

My Recommended Links

- https://www.peacehealth.org/apps/Forms/Default.asp?FormID=1191
- http://www.wwpp.org/media/fla/whatcomProf/whatcomProf.html
- http://www.wwpp.org/media/fla/BonnieWWPP2/TestVid.html
- http://www.wwpp.org/users/0000002/
- www.sharedcareplan.org
- www.wwpp.org
- www.connectingforhealth.org/resources/wg_eis_final_report_0704.pdf